Commonwealth of Massachusetts
Executive Office of Health and Human Services

June 2008 *Version 2.0*

Companion Guide

Health-Care Claim: Professional

For ASC X12N 837 (Version 4010A1)

Table of Contents

1.0 Introduction

1.1 What Is HIPAA?

The Health Insurance Portability and Accountability Act of 1996 – Administrative Simplification (HIPAA-AS) – requires that MassHealth, and all other health-insurance payers in the United States, comply with the electronic data interchange (EDI) standards for health care as established by the Secretary of Health and Human Services (HHS). HHS has adopted an Implementation Guide for each standard transaction. Version ASC X12N 837 of the 837 professional transaction is the standard established by HHS for professional claims submission.

1.2 Purpose of the Implementation Guide

The Implementation Guide for the 837 Professional claim transaction specifies in detail the required formats for claims submitted electronically to an insurance company, health-care payer, or government agency. The Implementation Guide contains requirements for use of specific segments and specific data elements within the segments, and was written for all health care providers and other submitters. It is critical that your software vendor or IT staff review this document carefully and follow its requirements to submit HIPAA-compliant files to MassHealth.

1.3 How to Obtain Copies of the Implementation Guides

The 837P Implementation Guides for X12N 837P Version 4010A1 and all other HIPAA standard transactions are available electronically at www.wpc-edi.com/HIPAA.

1.4 Purpose of This Companion Guide

The 837P Companion Guide was created for MassHealth trading partners by MassHealth to supplement the 837P Implementation Guide. It contains MassHealth-specific instructions for the following:

- data content, codes, business rules, and characteristics of the 837P transaction;
- technical requirements and transmission options; and
- information on testing procedures that each trading partner must complete before submitting 837P claims.

The information in this guide supersedes all previous communications from MassHealth about this electronic transaction. The following policies are in addition to those outlined in the MassHealth provider manuals for individual claim types. These policies in no way supersede MassHealth regulations. This companion guide should be used in conjunction with the information found in your MassHealth provider manual.

1.5 Intended Audience

The intended audience for this document is the technical staff responsible for submitting electronic 837P claims to MassHealth. In addition, this information should be shared with the

provider's billing office to ensure all required billing information is available for claim submission.

2.0 Establishing Connectivity with MassHealth

All MassHealth trading partners must sign a trading partner agreement (TPA). If you have elected to have a third party perform electronic transactions on your behalf you may be requested to complete a trading partner profile (TPP) form as well. Note that TPP information may be given over the telephone or the Provider Online Service Center in lieu of completing a paper form. If you have already completed these forms, you do not have to complete them again. Please contact MassHealth Customer Service at 1-800-841-2900 (See Section 2.6 - Support Contact Information) if you have any questions about these forms.

2.1 Setup

MassHealth trading partners should submit HIPAA 837P transactions to MassHealth via the Provider Online Service Center, or system-to-system using our Healthcare Transaction Service (HTS) process. Trading partners must contact MassHealth Customer Service at 1-800-841-2900 with questions about these options and to obtain a copy of the HTS guide.

.After establishing a transmission method, each trading partner must successfully complete trading partner testing. Information on this phase is provided in the next section of this Companion Guide. (See Section 2.2 - Trading Partner Testing.) After successful completion of testing, 837P transactions may be submitted for production processing.

We strongly encourage you to submit any electronic files directly to our Web portal so you can avoid a delay in processing your claims. By using our Web portal you can get a faster response on the status of your claims (e.g., if they will be paid or denied; if denied, with what error codes), so you can determine the problem and be able to resubmit the claims electronically in a more timely manner. We currently allow a user to submit a compact disc (CD) or diskette to MassHealth for claims submission, if you are unable to upload an electronic file to our Web site. If you have data (testing and production claims) on hard media, you must send it on a CD or diskette with the filename prominently displayed on the label, along with other information.

The external label on the hard media must appear as follows. *If this information is not clearly listed on the external label, you risk delays in processing your claims or potentially having the hard media returned to you.*

Header:	*MassHealth Submission*
File Name:	*As determined by the submitter following the appropriate file-naming convention for test or production claims*
Transaction Type:	*Institutional*
MassHealth Submitter/ Pay-to-Provider number:	*The MassHealth number of the provider or billing intermediary submitting the hard media*
Submitter Name:	*The name of the provider or billing intermediary submitting the hard media*
Submission Date:	*MM/DD/YY*
Contact Name:	*The name of the person to contact if MassHealth has a problem with the hard media*
Contact Information:	*Telephone number and/or e-mail address*

2.2 Trading Partner Testing

Please note that providers submitting single claims directly to MassHealth using via the Provider Online Service Center Web portal using direct data entry (DDE) the claims submission Web pages (direct data entry or DDE) are not required to test. You must, however, have a valid Trading Partner Agreement on file with MassHealth to submit claims

Before submitting production 837 claims to MassHealth, each trading partner must be tested. Trading partners planning to submit 837P transactions must contact MassHealth Customer Service at 1-800-841-2900 in advance to discuss the testing process, criteria, and schedule. Trading partner testing includes HIPAA compliance testing as well as validating the use of conditional, optional, and mutually defined components of the transaction.

If you are a current paper submitter or first-time submitter and want to test electronically with MassHealth we require the following.

- The test file must have a minimum of 10 and a maximum of 50 test claims.
- The member and provider data must be valid for a mutually agreed upon effective date.

The test files should contain as many types of claims as necessary to cover each of your business scenarios.

The following conditions must be addressed in one or more test files:

- original claims;
- void claims (if you plan to submit void transactions);
- replacement claims (if you plan to submit void transactions and replacement claims); and

- coordination of benefits (COB) claims, if you plan to submit COB claims.

Providers submitting test files containing COB claims (where the member has other insurance) should include a minimum of 10 and a maximum of 50 COB claims with the following criteria:

- claims with commercial insurance (denied/paid);
- claims with Medicare (denied/paid);
- claims with multiple insurance (if applicable); and
- claims with COB overrides, if applicable to the submitter only as described in provider bulletins).

All test files submitted on hard media, regardless of the type of services provided, must be submitted using the following naming convention for all media types:

- **T**YYYYYYY.ZZZ, where:
  - **T** indicates **T**est data.
  - YYYYYYYYYY is the 10-character MassHealth Submitter ID\Pay-to-Provider number.
  - ZZZ is the sequence number assigned to the file by the trading partner, starting with a value of "001".
  - This sequence number should be increased by one for each subsequent test file that is submitted. The sequence number will restart at 001 after it reaches 999.

Providers are advised to submit the 835 remittance advice and/or the paper explanation of benefits (EOB) from the other insurer to be used in the testing process for verification of data in the COB loops. Providers must indicate which claims on the 835 remittance advice and/or paper EOB correspond to the claims on the test file.

MassHealth will process these transactions in a test environment to validate that the file structure and content meet HIPAA standards and MassHealth-specific data requirements. Once this validation is complete, the trading partner may submit production 837P transactions to MassHealth for adjudication. **Test claims are adjudicated in the test system, but will not be adjudicated for payment.**

2.3 General Information for Member Name

The member name segment accepts and returns 30 characters as required in the Implementation Guide. However, If a value is submitted on a transaction that is greater than what is stored in the NewMMIS member database, on the return transaction the following would occur:(a) if a match is found on the database, the value stored on the database table is returned; (c) if no match is found on the database, the value stored on the original incoming transaction will be returned.

Example
A provider submits an eligibility verification check (270) with a name that is 22 characters long, but the database currently stores only 20 of those characters. On the return transaction (271), the provider will receive only the first 20 characters of the name submitted, if a match is found on the database. If for some reason, the member name submitted is not a MassHealth member, and is not stored on the database (no match found), on the return transaction (271) the name would be returned exactly as it was originally submitted.

2.4 Technical Requirements

The current maximum file size for any 837 file submitted to MassHealth is 16 megabytes. If you are uploading multiple 837 files using the transactions Web site, the maximum is 16 megabytes per upload, not per file. You can also submit your claims in a compressed zip file that contains no more than 99 claims. If you have questions, contact MassHealth Customer Service at 1-800-841-2900. (See Section 2.6 - Support Contact Information.)

MassHealth endorses the ASC recommendation that trading partners limit the size of the transaction (ST-SE envelope) to a maximum of 5,000 CLM segments. There is no recommended limit to the number of ST-SE transactions within a GS-GE or ISA-IEA.

2.5 Acknowledgements

Confirmation numbers are generated for all 837 transaction files uploaded to the Provider Online Service Center, indicating a successful file upload. 997 functional acknowledgements are generated for all 837 files submitted to MassHealth. These acknowledgements will be available for download from the Provider Online Service Center.

MassHealth uses the tilde (~) segment terminator on all outbound HIPAA-compliant transactions. HIPAA-compliant outbound transactions from MassHealth include the 835 electronic remittance advice transactions and the 997 acknowledgements.

2.6 Support Contact Information

All hard media containing claims must be mailed to the following address. To avoid delays in receiving your files, please use our Web portal.

MassHealth Customer Service
Phone: 1-800-841-2900
Fax: 617-988-8971
P.O. Box 9118
Hingham, MA 02043
E-mail: hipaasupport@mahealth.net

3.0 MassHealth-specific Submission Requirements

The following information is for production claims. For test claims refer to the Trading Partner Testing section.

The following sections outline recommendations, instructions, and conditional data requirements for 837P claims submitted to MassHealth. This information is designed to help trading partners construct 837 transactions in a manner that will allow MassHealth to efficiently process claims.

MassHealth expects the provider's national provider identifier (NPI) in the appropriate NM109 data element, and taxonomy code in the appropriate PRV data element, unless you are not required to use an NPI. If you are not required to use an NPI, your MassHealth 10-character

provider ID (comprised of nine digits and an alpha character to denote the service location) should be submitted in the appropriate REF02 data element with an REF01 qualifier of 1D.

3.1 Claims Attachments

An electronic standard for claims attachments has not been finalized by the Centers for Medicare and Medicaid Services (CMS). Until then, MassHealth has developed an alternative method for handling electronic claims that require attachments (for example, medical forms, consent forms, etc.) under HIPAA.

Note: "Attachments" does not refer to coordination of benefits (COB) attachments such as an explanation of benefits (EOB) from another insurer. See Section 3.3 - Coordination of Benefits (COB) Claims for more information**.**

Claims that require attachments can be submitted through the Provider Online Service Center. Claim attachments can be uploaded and submitted with claims using the Direct Data Entry (DDE) panels.

Until a standard for electronic attachments is finalized by CMS, providers and billing intermediaries submitting HIPAA claims to MassHealth must follow the direct data entry (DDE) process to properly adjudicate claims requiring attachments. This does not alter the current method of claim and attachment submission via paper which will continue to be available to providers.

MassHealth has reviewed its requirements for attachments, and will allow the following attachments to be kept on file in the office rather than to be submitted with the claim or through the DDE process.

If you submit this type of attachment…	and you are this provider type…	you may keep the attachment on file (code to enter in PWK02)
Certification for Payable Abortion (CPA-2) form	Abortion Clinic Family Planning Clinic Freestanding Ambulatory Surgical Center Physician	PWK02 = AA
Medical necessity form for other licensed carriers (Medflight, etc.)	Transportation	PWK02 = AA

Please refer to Section 3.6 - Detail Data for instructions on completing the PWK segment.

All attachments not listed above (with the exception of coordination of benefits attachments such as an explanation of benefits) must continue to be submitted, either with a paper claim or via the DDE process.

Periodically, MassHealth may ask providers to verify the completion of attachments kept on file. In cases where MassHealth reviews have revealed provider noncompliance with the recordkeeping requirements of 130 CMR 450.205(A) through (C), MassHealth may pursue any legal remedies available to it, including but not limited to recovery of overpayments and imposing sanctions in accordance with the provisions of 130 CMR 450.234 through 450.260.

3.2 Encounter Claims

MassHealth will not accept encounter claims. For further details, see Section 3.6 - Detail Data.

3.3 Coordination of Benefits (COB) Claims

The implementation of the 837 transaction enables providers to submit claims for members with other insurance electronically to MassHealth, after billing all other resources. The Centers for Medicare and Medicaid Services (CMS) has consolidated the Medicare claims crossover process by appointing a single coordination of benefits contractor (COBC) by means of the coordination of benefits agreement (COBA) initiative. Under the COBA, claims for dually entitled (Medicare/Medicaid) members that have been approved by Medicare will be forwarded electronically to MassHealth by the COBC. Claims where Medicare is the secondary payer or the member has Medicare supplemental insurance must be submitted to MassHealth by the provider. For more information about COBA, please refer to the COBA Implementation User Guide located at http://www.cms.hhs.gov/medicare/cob/coba.asp.

When submitting an 837 transaction to MassHealth for members with other insurance, providers must supply the other payer's adjudication details that were provided on that insurer's 835 or paper remittance transaction. Providers are required to enter the other payer's adjudication details at the claim. The adjustment reason codes entered in the COB loops should be the exact codes given by the other payer. Altering the adjudication details given by the other payer is considered fraudulent.

In addition, since the national plan ID is not mandated yet, MassHealth requires providers to enter the MassHealth-assigned carrier code on the 837 transaction to identify the other insurance. The Eligibility Verification System (EVS) will provide a seven-digit insurance carrier code for all applicable insurance coverage for a member.
After billing all resources prior to billing MassHealth, enter the first four digits of the other payer(s) carrier code(s) on the 837 transaction. To ensure accurate processing, the four-digit carrier codes entered on the 837 transaction must match the first four digits of the carrier code provided by EVS. See Section 3.7 - Detail Data for COB Claims for more details.

3.3.1 COB Bundled Claims

MassHealth processes claims for services that are bundled by commercial insurance or Medicare as a bundled claim. If you need to make a correction to a bundled claim, you must void all paid service lines associated with the bundled claim, make the necessary corrections to the claim, and resubmit the bundled claim as an original 837 transaction.

3.4 Void Transactions

Under HIPAA guidelines, adjustments to paid claims should be submitted as a void/replace transaction.

Void transactions are used by submitters to correct and report any one of the following situations:

- duplicate claim erroneously paid;
- payment to the wrong provider;
- payment for the wrong member;
- payment for overstated or understated services; and
- payment for services for which payment has been received from third-party payers.

Void transactions must be submitted at the claim-header level and must include the original MassHealth-generated internal control number (ICN) for the service as the "Former ICN" with a claim frequency code equal to "8".

3.5 Production File-naming Convention

837 files transmitted to MassHealth using the Provider Online Service Center may use any convenient file-naming convention. The system will rename files upon receipt and issue a tracking number for reference. 837 files transmitted to MassHealth via hard media must adhere to the following naming convention:

- **H**YYYYYYYYYY.ZZZ, where
  - **H** indicates a **H**IPAA-compliant production file.
  - YYYYYYYYYY is the 10-character MassHealth submitter/pay-to-provider number.
  - ZZZ is the sequence number assigned to the file starting with a value of "001." The sequence number should be increased by one for each subsequent file that is submitted. The sequence number will restart at 001 after it reaches 999.

3.6 Detail Data

Although submitters can view the entire set of required data elements in the 837P Implementation Guide, MassHealth recommends that submitters pay special attention to the following segments as these segments have already generated questions.

Loop	Segment		Element Name	Companion Information
----	ISA	01	Authorization Information Qualifier	"00"
----	ISA	02	Authorization Information	10 blanks
----	ISA	03	Security Information Qualifier	"00"
----	ISA	04	Security Information	10 blanks

Loop	Segment		Element Name	Companion Information
----	ISA	05	Interchange Sender ID Qualifier	Enter “ZZ”
----	ISA	06	Interchange Sender ID	Your 10-character MassHealth submitter ID or your ten-character MassHealth provider ID/service location number.
----	ISA	07	Interchange Receiver ID Qualifier	Enter “ZZ.”
----	ISA	08	Interchange Receiver ID	Enter “DMA7384.”
----	ISA	14	Acknowledgement Requested	“0”
-----	ISA	15	Interchange Usage Indicator	This element is used to indicate whether the transmission is in a test or production mode. A “P” indicates production data, and a “T” indicates test data.
----	GS	02	Application Sender’s Code	Your 10-character MassHealth submitter ID or your 10-character MassHealth provider ID service location ID number.
----	GS	03	Application Receiver's Code	Enter “DMA7384.”
----	BHT	06	Transaction Type Code	In the Beginning of Hierarchical Structure (BHT) loop, BHT06 should always be equal to "CH" and all submitted 837 transactions should be claims for payment.
1000A	NM1	09	Submitter Identification Code	Your 10-character MassHealth submitter ID or your 10-character MassHealth provider ID service location number.
1000B	NM1	09	Receiver Identification Code	Enter ”DMA7384.”
2000A	PRV	03	Provider Taxonomy Code	Enter taxonomy code, if providers are instructed to enter taxonomy code.
2010AA	NM	109	Identification Code Qualifier	Enter NPI OR provider ID + Svc Location (As value entered in 2010AA = REF02)
2000B	SBR	09	Subscriber Information Claim Filing Indicator Code	Enter ”MC.”
2010BA	NM1	09	Subscriber Name/Identification Code	The 12-character MassHealth Member’s identification number when NM108 is “MI” and NM102 is “1.”
2010BB	NM1	08	Payer Identification	Enter “PI.”

Loop	Segment		Element Name	Companion Information
2010BB	NM1	09	Identification Code	Enter “046002284.”
2300	REF	01/02	Prior Authorization or Referral Number	If prior authorization exists, place “G1” in REF01 and place the MassHealth assigned 10-character prior-authorization number in REF02 (also see 2400 REF01/REF02 Prior Authorization or Referral Number). **Note:** Multiple PAs should not be entered in the 2300 loop at the claim level. Multiple PAs on a claim may be billed in one of two ways. A PA that applies to a majority of the services being billed may be entered in the 2300 loop at the claim line level, with any additional PAs billed in the appropriate 2400 loop service line level. Alternatively, PAs may be entered in the appropriate 2400 loop service line level only, with no entry in the 2300 loop claim level.
2300	REF	01/02	Prior Authorization or Referral Number	Enter “9F” in REF01 and the ten-character referral number in REF02 if the member you are billing is enrolled in a PCC Plan and all services being billed for require PCC authorization (also see 2400 REF01/REF02 prior authorization or referral number).
2300	REF	01/02	Original Reference Number/Reference Identification	If submitting a void or replace transaction, enter “F8” in REF01 and the 13-character internal control number (ICN) from the original claim.
2300	AMT	01/02	Patient Estimated Amount Due	If there is a member co-pay associated with the services rendered, enter “F5” in AMT01 and the amount of the co-pay in AMT02.
2300	CLM	05-3	Claim Frequency Type Code	UB-04 – Claim frequency type code value **Code** **Definition** 7 Replacement 8 Void
2300	PWK	02	Report Transmission Code	Enter AA (Available on Request at Provider Site). Claims submitted with a transmission code of AA will notify MassHealth that the attachment is one of the approved attachments allowed to be kept on file at the provider’s office.

Loop	Segment		Element Name	Companion Information
2300	HI	01-1 to 01-7, 02-1 to 02-7, 03-1 to 03-7, 04-1 to 04-7, 05-1 to 05-7, 06-1 to 06-7, 07-1 to 07-7, 08-1 to 08-7, 10, 11, 12	Health Care Diagnosis Code	To determine if you are required to enter a diagnosis code, refer to Subchapter 5 (Billing Instructions, Section 5.3 of your provider manual), and follow the instructions for the use of diagnosis codes.
2310A	NM1	09	Referring Provider Name	Enter “NPI.”
2310B	NM1	09	Referring Provider Name	Enter “NPI.”
2320	AMT	02	Monetary Amount	Enter the Medicare allowed AMOUNT, when this loop reports Medicare as the prior payer (2320:SBR09 = MB)
2320	CAS		Claims Adjustment Code	When coinsurance, deductible or psych reduction is populated the CAS adjustment group code should be 'PR'
2400	SV1	01-3	Professional Service/Procedure Modifier	SV101-1 requires a product/service qualifier and SV101-2 requires a procedure code. If you are billing for pharmaceuticals, continue to use the HCPCS code (sometimes known as J-code). If you are a transportation provider, you should combine the one-character origin and destination modifiers into one two-character modifier and populate the first occurrence of modifier with the result.
2400	SV1	04	Quantity	Service Unit Counts 1 Unit = 15 Minutes
2400	REF	01/02	Prior Authorization or Referral Number	Enter “G1” in REF01 and the ten-character prior authorization number in REF02 if the service being billed on this line requires prior authorization and the prior authorization number is **different from or was not already entered** in the 2300 Loop (also see 2300 REF01/REF02 prior authorization or referral number identification).

Loop	Segment		Element Name	Companion Information
2400	REF	01/02	Prior Authorization or Referral Number	Enter "9F" in REF01 and the ten-character referral number in REF02 if the member you are billing is enrolled in a PCC Plan and the service being billed on this line requires PCC authorization and the referral number was not already entered in the 2300 Loop (also see 2300 REF01/REF02 prior authorization or referral number information).
2400	AMT	02	Monetary Amount	Enter the Medicare allowed amount for this service, when Medicare allowed amount for the claim is > 0. (2320:SBR09 is MB and 2320:AMT02(AMT01=B6) > 0)
2420A	NM1	09	Rendering Provider Name	Enter "NPI."
2420F	NM1	09	Referring Provider Identifier	Enter "NPI."
2430	CAS		Claim Adjustment Group Code	When coinsurance, deductible or psych reduction is populated the CAS adjustment group code should be 'PR'

Please Note: If you are not required to enter a diagnosis on a paper claim, you are not required to enter one on the 837 transaction.

3.7 Detail Data for COB Claims

Loop	Segment		Element Name	Companion Information
2300	CLM	07	Provider Accept Assignment Code	For all crossover claims, MassHealth requires the value of "A." Claims will not pay if the field is not used or is sent with another value.
2330B	NM1	08	Identification Code Qualifier	Enter the value "PI" for payer identification.
2330B	NM1	09	Other Payer Primary Identifier	MassHealth assigned four-digit carrier code when NM108 is "PI" (see Appendix C: Third-Party-Liability Codes in your provider manual or refer to the Provider Library at www.mass.gov/masshealth for information.)
2430	SVD		Service Line Adjudication Information	Required if other payer has adjudicated the service line
2430	SVD	02		Paid amount (When SVD01 is matched up with 2330B:NM109 and 2320:SBR09=MB)

3.8 Additional Information

MassHealth does not process certain loops that do not apply to the MassHealth business model. For example, MassHealth does not process 2000C Patient Hierarchical Level since there is no dependent coverage (all members are subscribers**).** In certain circumstances, these loops may be required in a compliant 837 transaction. However, the data content of these loops will not affect the MassHealth claims adjudication process.

3.9 Service Codes

Please consult Subchapters 5 and 6 of your MassHealth provider manual for information on acceptable service codes. The information is also available on the Web.

4.0 Sample MassHealth Transactions

Example of MassHealth 837P Transaction

```
ISA*00* *00* *ZZ*990454999A *ZZ*DMA7384 *070402*1557*U*00401*000000022*1*T*:~
GS*HC*153605299A*DMA7384*20070402*1557*22*X*004010X098A1~
ST*837*0001~
BHT*0019*00*3920394930203*20070401*1557*CH~
REF*87*004010X098A1~
NM1*41*2*MEDICAL CLAIM CORP*****46*990454999A~
PER*IC*MR SLATE*TE*5555551234*FX*5555554321~
NM1*40*2*MASSHEALTH*****46*DMA7384~
HL*1**20*1~
PRV*PE*ZZ*103T00000X~
NM1*85*2*RUBBLE, BARNEY*****XX*3624880410~
N3*2 SLATE WAY~
N4*BEDROCK*MA*12345~
REF*SY*012345678~
NM1*87*2*CURTIS, STONY*****XX*4642880111~
N3*7 HOLLYROCK BLVD~
N4*HOLLYROCK*CA*52101~
HL*2*1*22*0~
SBR*P*18**BEDROCK HEALTH*****MC~
NM1*IL*1*FLINTSTONE*WILMA****MI*987987987777~
N3*4 SLATE WAY~
N4*BEDROCK*MA*12345~
DMG*D8*19511204*F~
NM1*PR*2*MASSHEALTH*****PI*046002284~
CLM*9.1.3*40***11::1*Y*A*Y*Y*C*EM:AA::MA~
DTP*435*D8*20070313~
DTP*096*D8*20070313~
DTP*439*D8*20070313~
PWK*EB*AA***AC*BLAH~
REF*G1*131313~
REF*F8*5858585~
HI*BK:6800*BF:8600*BF:2855~
NM1*82*2*FLINTSTONE, FRED*****24*362488041~
PRV*PE*ZZ*103T00000X~
REF*1D*2000000~
LX*1~
SV1*HC:51421:11*10*UN*1*11**2**Y**Y*Y~
DTP*472*RD8*20070331-20070401~
REF*G1*69875~
NM1*82*2*FLINTSTONE, FRED*****24*362488041~
PRV*PE*ZZ*103T00000X~
REF*1D*1414141~
LX*2~
SV1*HC:55551:56:25*10*UN*1*11**2:3~
DTP*472*D8*20030331~
LX*3~
SV1*HC:7777*10*UN*1*11**3****Y~
DTP*472*RD8*20070330-20070331~

LX*4~
SV1*HC:54321:25:14:16*10*UN*1*11**3**Y~
DTP*472*D8*20070331~
REF*9F*0123456~
NM1*82*2*FLINTSTONE, FRED*****24*362488041~
PRV*PE*ZZ*103T00000X~
REF*1D*0123456~
SE*54*0001~
GE*1*22~
IEA*1*000000022~
```

COB Claim

ISA*00* *00* *ZZ*060563899A *ZZ*DMA7384 *030109*1000*U*00401*000000170*0*T*:~
GS*HC*153605299A*063706031*200730109*1000*1*X*004010X098A1~
ST*837*0001~
BHT*0019*00*3920394930203*20021202*1615*CH~
REF*87*004010X098A1~
NM1*41*1*KECY*KEVIN*T***46*9012345918341~
PER*IC*KEVIN KECY*ED*6175551212*TE*6175555555*EM*KKECY@MAIL.US~
NM1*40*2*MASSHEALTH*****46* DMA7384~
HL*1**20*1~
PRV*PE*ZZ*341600000X~
NM1*85*2*YERUVA*****XX*0435879600~
N3*PO BOX 123*157 WEST 57TH STREET~
N4*BOSTON*MA*02101*US~
REF*SY*012345678~
NM1*87*2*GROUP NAME*****XX*1123456789~
N3*123 SUMMER STREET~
N4*BOSTON*MA*012110000~
REF*SY022345678
HL*2*1*22*0~
SBR*P*18*500*MAGGIE MCXXX**1***09~
NM1*IL*1*JYYY*JOHN****MI*025746892555~
N3*123 WINTER STREET~
N4*BOSTON*MA*012110000~
DMG*D8*19990506*F~
NM1*PR*2*MASSHEALTH*****PI*046002284~
CLM*2.1.3.10*74.00***11::1*Y**Y*N~
HI*BK:4659~
SBR*P*19*28161*CARPENTER S UNION*****CI~
CAS*PR*2*34.00~
DMG*D8*19700601*F~
OI***Y***Y~
NM1*IL*1*NZZZZ*WILLIAM****MI*527479999~
NM1*PR*2*payer name*****PI*9999~
LX*1~
SV1*HC:99213*74.00**10*I*1~
DTP*472*D8*20071113~
SVD*9999*30.00*HC:99213**1~
CAS*PR*1*10.00~
DTP*573*D8*20071203~
SE*36*0001~
GE*1*1~
IEA*1*000000170~

5.0 Version Table

Version	Date	Section/Pages	Description
	2/13/03	Entire document	Initial document created
1.0	2/24/03	Entire document	Draft revised with updated MassHealth template
1.1	3/3/03	Entire document	Draft revised after BA review
1.2	4/8/03	Entire document	Draft revised after 837P edits were applied
1.3	4/29/03	Entire document	Final revisions
1.4	5/03	Entire document	Draft revised after 837P edits applied
1.5	6/03	Entire document	Draft version posted on Web
1.6	6/30/03	Minor reformatting of entire document	Production version issued
1.7	9/11/03	Entire document	Production version issued
1.8	11/24/03	Links/text updated throughout document	Production version issued
1.9	1/16/04	Revisions to pages 12, 15, 21	Additional hospice information added to service codes section and provider types Map
2.0	5/18/04	Revisions to section 2.4	Production version issued
2.1	7/02/04	Revision to page 11	Production version issued
2.2	12/09/04	Update to Section 2.4 to reflect new Secure File Data information	Production version issued
2.3	5/18/05	Updates to Sections 2.3, 2.5, 3.0, 3.7, 3.9, Appendix B and Appendix C to reflect TPA and 60-day noticing	Draft version issued. Production issue to follow.
2.4	10/05/05	Update to Sections 2.3 regarding zip file submissions, 2.5 regarding support contact information, 3.1 zip code update, 3.5 update to file naming conventions, 3.6 update to Detail Data tables, and 3.10 regarding support contact information	Production version issued
1	03/08	Entire document	Significant revisions throughout guide to reflect NewMMIS requirements
2.0	06/08	Entire document	Additional revisions throughout guide to reflect NewMMIS requirements, based on feedback from Version 1.0

Appendix A: Frequently Asked Questions

Q: How can I receive 997 functional acknowledgements for rejects at the claim level rather than the transaction-set level?

A: The 997 acknowledges rejection of all claims within the ST/SE boundary. The only way to receive a 997 rejection for each invalid claim is to submit your 837s with only one claim per transaction set.

Q: When applicable, should I use the place-of-service codes contained in the HIPAA Implementation Guide when submitting MassHealth paper claim forms too?

A: Yes. When submitting paper claim forms requiring a place-of-service code, use the appropriate place-of-service code found in the HIPAA Implementation Guide.

Q: MassHealth has allowed dentists who specialize in oral surgery to enroll and bill for dental procedures using the CDT codes and the CPT codes for oral surgery services. The 837 Dental Implementation Guide states that CDT codes are the only service codes allowed when filing an electronic claim. What is the process to submit claims for oral surgery services using a CPT code?

A: Submit oral surgery claims with CPT codes using the 837P claim format.

Q. If I identify other insurance that is not on file with MassHealth, how do I submit the claim?

A. Follow the standard process for any coordination of benefits (COB) claim. To obtain the MassHealth-assigned carrier code, cross-reference the insurance name with the appropriate carrier code in Appendix C of your provider manual, and enter the first three comments: should be first 4 digits of the code on your 837 transaction. Concurrently, you should request that the MassHealth file be updated by sending all pertinent information to the appropriate address below:

MassHealth	**or**	**MassHealth**
Third Party Liability Unit P.O. Box 9219 Chelsea, MA 02150 Fax: 617-357-7604		Medicare Unit Schraffts Center 529 Main Street, 3rd Floor Charlestown, MA 02129-1120 Fax: 617-886-8134

Do not send claim forms to these addresses.

Appendix B: Provider Types to Invoice Types Map

If you currently submit claims on a CMS-1500 form and you are this provider type	… and you are billing this allowable service[1]	… then use this HIPAA transaction
Acute Inpatient Hospital	Professional service	837P
Acute Outpatient Hospital	Professional service	837P
Freestanding Ambulatory Surgery Center	Ambulatory surgery service	837P
Group Practice Organization	Physician service	837P
Hospital Licensed Health Center	Professional service	837P
Imaging Center/Portable X-Ray	Imaging or X-ray service	837P
Nurse Midwife	Nurse midwife service	837P
Nurse Practitioner	Nurse practitioner service	837P
Physician	Physician service	837P
Radiation & Oncology Treatment Centers	Radiation or oncology treatment service	837P
Acute Outpatient Hospital	Ambulance service	837P
Chronic Outpatient Hospital	Ambulance service	837P
Hospital Licensed Health Center	Ambulance service	837P
	Ambulance service	837P
	Transportation service	837P
	Abortion/sterilization service	837P
	Adult day health, adult foster care, hearing aid dispensing service, early intervention service, psychiatric day treatment service, or vision care service	837P
	Adult day health services	837P
	Adult foster care service, group adult foster care service or head injury rehabilitation/community reintegration service	837P

If you currently submit claims on a CMS-1500 form and you are this provider type	… and you are billing this allowable service[1]	… then use this HIPAA transaction
	AIDS targeted case management or group adult foster care service	837P
	Audio logical and hearing aid dispensing service	837P
	Certified independent laboratory service	837P
	Chapter 766 service	837P
	Chiropractic service	837P
	Adult day health, adult foster care, hearing aid dispensing service, early intervention service, psychiatric day treatment service or vision care service	837P
	CPT codes (with the exception of home health services, which must be billed on an 837I)	837P
	Day habilitation service	837P
	Early intervention service	837P
	Family planning service	837P
	Fiscal intermediary service for a PCA	837P
	medical service	837P
	Hearing aid service	837P
	Elderly waiver services	837P
	Adult day health, adult foster care, hearing aid dispensing service, early intervention service, psychiatric day treatment service, or vision care service	837P
	Independent living service	837P
	Indian health service	837P
	Medical supply or durable goods item	837P
	Mental health service	837P

If you currently submit claims on a CMS-1500 form and you are this provider type	… and you are billing this allowable service[1]	… then use this HIPAA transaction
	Nursing service	837P
	Adult day health service	837P
	Vision care service	837P
	Vision care service	837P
	Vision care service	837P
	Vision care service	837P
	Orthotic device	837P
	Oxygen & respiratory therapy equipment item	837P
	Personal care service	837P
	Durable medical equipment item	837P
	Podiatrist service	837P
	Prosthetic device	837P
	Psychiatric day treatment service	837P
	Psychiatric day treatment service	837P
	Psychologist Service	837P
	Rehabilitation service	837P
	Renal dialysis service	837P
	Speech and hearing service	837P
	State agency service	837P
	Municipal medicaid service	837P
	Substance abuse service	837P
	Therapist service	837P
	Volume purchaser service	837P
	Oral surgery service (using CPT code)[2]	837P
	Oral surgery service (using CPT code)[2]	837P
	CPT code/oral surgery service (using CPT code)[2]	837P
	Oral surgery service (using CPT	837P

If you currently submit claims on a CMS-1500 form and you are this provider type	… and you are billing this allowable service[1]	… then use this HIPAA transaction
	code) [2]	

[1] Please consult the most recent Subchapter 6 and Appendix E of your provider manual for information on acceptable revenue and service codes.

[2] If you are billing for an American Dental Association code also referred to as a Current Dental Terminology (CDT) code, use the 837D transaction and submit your claims to Doral. For more information please refer to the MassHealth 837D Companion Guide at MassHealth Companion Guides.

Appendix C: Links to Online HIPAA Resources

The following is a list of online resources that may be helpful.

Accredited Standards Committee (ASC X12)

- ASC X12 develops and maintains standards for inter-industry electronic interchange of business transactions. www.x12.org

American Hospital Association Central Office on ICD-9-CM (AHA)

- This site is a resource for the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes, used in medical transcription and billing, and for Level I HCPCS. www.ahacentraloffice.org

American Medical Association (AMA)

- This site is a resource for the Current Procedural Terminology 4th Edition codes (CPT-4). The AMA copyrights the CPT codes. www.ama-assn.org

Association for Electronic Health-care Transactions (AFEHCT)

- AFEHCT is a health-care association dedicated to promoting the interchange of electronic health-care information. www.afehct.org

Centers for Medicare and Medicaid Services (CMS)

- CMS, formerly known as HCFA, is the unit within HHS that administers the Medicare and Medicaid programs. CMS provides the Electronic Health Care Transactions and Code Sets Model Compliance Plan at: www.cms.hhs.gov/default.asp?fromhcfadotgov=true
- This site is the resource for information related to the Health-care Common Procedure Coding System (HCPCS). www.cms.hhs.gov/MedHCPCSGenInfo

Designated Standard Maintenance Organizations (DSMOs)

- This site is a resource for information about the standard-setting organizations and transaction change request system. www.hipaa-dsmo.org

Health Level Seven (HL7)

- HL7 is one of several ANSI accredited Standards Development Organizations (SDO), and is responsible for clinical and administrative data standards. www.hl7.org

MassHealth

- The MassHealth Web site assists providers with MassHealth billing and policy questions as well as provider enrollment support. www.mass.gov/masshealth

National Council of Prescription Drug Programs (NCPDP)

- The NCPDP is the standards and codes development organization for pharmacy. www.ncpdp.org

National Uniform Billing Committee (NUBC)

- NUBC is affiliated with the American Hospital Association and develops standards for institutional claims. www.nubc.org

National Uniform Claim Committee (NUCC)

- NUCC is affiliated with the American Medical Association. It develops and maintains a standardized data set for use by the non-institutional health-care organizations to transmit claims and encounter information. NUCC maintains the national provider taxonomy. www.nucc.org

Office for Civil Rights (OCR)

- OCR is the office within Health and Human Services responsible for enforcing the Privacy Rule under HIPAA. www.hhs.gov/ocr/hipaa

United States Department of Health and Human Services (DHHS)

- The DHHS Web site is a resource for the Notice of Proposed Rule Making, rules and other information about HIPAA. www.aspe.hhs.gov/admnsimp

Washington Publishing Company (WPC)

- WPC is a resource for HIPAA-required transaction implementation guides and code sets. www.wpc-edi.com/HIPAA

Workgroup for Electronic Data Interchange (WEDI)

- WEDI is a workgroup dedicated to improving health-care through electronic commerce, which includes the Strategic National Implementation Process (SNIP) for complying with the administrative-simplification provisions of HIPAA. www.wedi.org